FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039339

Facility Name: Jerseyville Nursing and Rehabilitation Center

Address: 1001 South State Street (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6496 **Fax #** (618) 498-7435

IDPA ID Number: 37-1323741

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		11,617	5,290	16,907	8
9	SNF/PED					9
10	ICF	18,126			18,126	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,126	11,617	5,290	35,033	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.03%

D. How many bed-hold days during this year were paid by Public Aid?
43 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 25 and days of care provided 5,290

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	171,960	14,810	3,728	190,498		190,498		190,498			1
2	Food Purchase		180,004		180,004		180,004	(1,492)	178,512			2
3	Housekeeping	87,299	13,740		101,039		101,039		101,039			3
4	Laundry	75,244	18,294		93,538		93,538		93,538			4
5	Heat and Other Utilities			108,599	108,599		108,599	772	109,371			5
6	Maintenance	44,349	5,348	18,743	68,440		68,440	1,034	69,474			6
7	Other (specify):* Waste Removal			12,182	12,182		12,182		12,182			7
8	**TOTAL General Services**	378,852	232,196	143,252	754,300		754,300	314	754,614			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,214,493	95,348	8,720	1,318,561	172	1,318,733	(952)	1,317,781			10
10a	Therapy	37,555	467	366,333	404,355		404,355	(58,126)	346,229			10a
11	Activities	34,664	3,300	1,318	39,282	780	40,062		40,062			11
12	Social Services	57,902	54	1,318	59,274		59,274		59,274			12
13	Nurse Aide Training					2,563	2,563		2,563			13
14	Program Transportation		2,048		2,048		2,048		2,048			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,344,614	101,217	387,289	1,833,120	3,515	1,836,635	(59,078)	1,777,557			16
	C. General Administration											
17	Administrative	72,986	5,562	217,047	295,595	(3,147)	292,448	(111,417)	181,031			17
18	Directors Fees											18
19	Professional Services			54,368	54,368		54,368	9,730	64,098			19
20	Dues, Fees, Subscriptions & Promotions			27,236	27,236	(264)	26,972	(9,218)	17,754			20
21	Clerical & General Office Expenses	49,074	17,917	89,941	156,932		156,932	24,588	181,520			21
22	Employee Benefits & Payroll Taxes			281,393	281,393		281,393	15,142	296,535			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,489	7,489	(136)	7,353	3,772	11,125			24
25	Other Admin. Staff Transportation							5,981	5,981			25
26	Insurance-Prop.Liab.Malpractice			49,450	49,450		49,450	5,141	54,591			26
27	Other (specify):*											27
28	**TOTAL General Administration**	122,060	23,479	726,924	872,463	(3,547)	868,916	(56,281)	812,635			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,845,526	356,892	1,257,465	3,459,883	(32)	3,459,851	(115,045)	3,344,806			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center #0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			179,989	179,989		179,989	4,228	184,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			310,223	310,223		310,223	(15,141)	295,082			32
33	Real Estate Taxes			44,692	44,692		44,692	778	45,470			33
34	Rent-Facility & Grounds							5,350	5,350			34
35	Rent-Equipment & Vehicles			7,712	7,712		7,712	2,360	10,072			35
36	Other (specify):* Mortgage Ins.			18,266	18,266		18,266		18,266			36
37	TOTAL Ownership			560,882	560,882		560,882	(2,425)	558,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,639	17,306	189,945		189,945		189,945			39
40	Barber and Beauty Shops					32	32		32			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		172,639	72,603	245,242	32	245,274		245,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,845,526	529,531	1,890,950	4,266,007		4,266,007	(117,470)	4,148,537			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(669)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,737)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,475)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,475)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,020)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,230)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,606)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(93,864)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (93,864)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,470)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		32	17	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 32		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jerseyville Nursing and Rehabilitation Center

ID# 0039339

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	$ (823)	2	1
2	Offset Miscellaneous Income Against Expense	(952)	10	2
3	Offset Miscellaneous Income Against Expense	(371)	21	3
4	Eliminate PAC & Lobbying Dues	(2,128)	20	4
5	Eliminate Tax Penalties	(635)	20	5
6	Eliminate Additional Meals & Entertainment	(162)	17	6
7	To Add 2003 IDPH License Paid in 2002	200	20	7
8	Eliminate Chamber of Commerce Dues	(350)	20	8
9	Eliminate Non-Care Related Travel	(725)	24	9
10	Eliminate Duplicate Seminar Payment	(284)	24	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,230)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,492)	0	0	0	0	0	0	0	0	0	0	(1,492)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	772	0	0	0	0	0	0	0	0	0	772	5
6	Maintenance	0	1,034	0	0	0	0	0	0	0	0	0	1,034	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,492)	1,806	0	0	0	0	0	0	0	0	0	314	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(952)	0	0	0	0	0	0	0	0	0	0	(952)	10
10a	Therapy	0	0	(58,126)	0	0	0	0	0	0	0	0	(58,126)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(952)	0	(58,126)	0	0	0	0	0	0	0	0	(59,078)	16
	C. General Administration													
17	Administrative	(162)	105,792	(217,047)	0	0	0	0	0	0	0	0	(111,417)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,658	7,072	0	0	0	0	0	0	0	0	9,730	19
20	Fees, Subscriptions & Promotions	(10,408)	1,190	0	0	0	0	0	0	0	0	0	(9,218)	20
21	Clerical & General Office Expenses	(371)	24,959	0	0	0	0	0	0	0	0	0	24,588	21
22	Employee Benefits & Payroll Taxes	0	15,142	0	0	0	0	0	0	0	0	0	15,142	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,484)	7,256	0	0	0	0	0	0	0	0	0	3,772	24
25	Other Admin. Staff Transportation	0	5,981	0	0	0	0	0	0	0	0	0	5,981	25
26	Insurance-Prop.Liab.Malpractice	0	5,141	0	0	0	0	0	0	0	0	0	5,141	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,425)	168,119	(209,975)	0	0	0	0	0	0	0	0	(56,281)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,869)	169,925	(268,101)	0	0	0	0	0	0	0	0	(115,045)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	4,228	0	0	0	0	0	0	0	0	0	4,228	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,737)	62	(8,466)	0	0	0	0	0	0	0	0	(15,141)	32
33	Real Estate Taxes	0	778	0	0	0	0	0	0	0	0	0	778	33
34	Rent-Facility & Grounds	0	0	5,350	0	0	0	0	0	0	0	0	5,350	34
35	Rent-Equipment & Vehicles	0	0	2,360	0	0	0	0	0	0	0	0	2,360	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,737)	5,068	(756)	0	0	0	0	0	0	0	0	(2,425)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,606)	174,993	(268,857)	0	0	0	0	0	0	0	0	(117,470)	45

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Montgomery Nursing & Rehabilitation Center	Hillsboro, IL	Wellington Mgmt Co.	Chesterfield, MO	Management Co
David L. Kamler	10.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co
J. Terry Dooling	10.00	Spanish Lake Nursing & Rehabilitation Center	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
R.J. Tolliver	10.00			NW Rehab, L.L.C.	Alton, IL	Therapy Co.
Jack A. Yaeger	10.00			Three Amigos of Spani	Alton, IL	Real Estate Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 772	$ 772	1
2	V	6	See Schedule VIII		Wellington Management Co.	60.00%	1,034	1,034	2
3	V	17	See Schedule VIII		Wellington Management Co.	60.00%	105,792	105,792	3
4	V	19	See Schedule VIII		Wellington Management Co.	60.00%	2,658	2,658	4
5	V	20	See Schedule VIII		Wellington Management Co.	60.00%	1,190	1,190	5
6	V	21	See Schedule VIII		Wellington Management Co.	60.00%	24,959	24,959	6
7	V	22	See Schedule VIII		Wellington Management Co.	60.00%	15,142	15,142	7
8	V	24	See Schedule VIII		Wellington Management Co.	60.00%	7,256	7,256	8
9	V	25	See Schedule VIII		Wellington Management Co.	60.00%	5,981	5,981	9
10	V	26	See Schedule VIII		Wellington Management Co.	60.00%	5,141	5,141	10
11	V	30	See Schedule VIII		Wellington Management Co.	60.00%	4,228	4,228	11
12	V	32	See Schedule VIII		Wellington Management Co.	60.00%	62	62	12
13	V	33	See Schedule VIII		Wellington Management Co.	60.00%	778	778	13
14	Total			$			$ 174,993	$ * 174,993	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 5,350	$ 5,350	15
16	V	35	See Schedule VIII		Wellington Management Co.	60.00%	2,360	2,360	16
17	V	17	Management Fees	156,274	Wellington Management Co.	60.00%		(156,274)	17
18	V	17	Management Fees	60,773	Health Care Financial, L.L.C.	40.00%		(60,773)	18
19	V	19	Professional Services	44,959	C.J. Schlosser & Company, L.L.C.	40.00%	52,031	7,072	19
20	V	10a	Therapy Services	366,333	NW Rehab, L.L.C.	100.00%	308,207	(58,126)	20
21	V	32	Interest	8,466	John H. Rothert	60.00%		(8,466)	21
22	V	19	Professional Services	1,150	Montgomery Nursing & Rehabilitation Center	0.00%	1,150		22
23	V	10	Nurse Consultant	6,104	Wellington Management Co.	60.00%	6,104		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 644,059			$ 375,202	$ * (268,857)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	171,337	12.3	31.00	Salary	$ 76,111	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 76,111		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636) 537-8447
Fax Number: (636) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	11,968,251	5	$ 2,509	$	3,681,234	$ 772	1
2	6	Maintenance	Accumulated Costs	11,968,251	5	3,361		3,681,234	1,034	2
3	17	Administrative	Accumulated Costs	11,968,251	5	343,945	343,945	3,681,234	105,792	3
4	19	Professional Services	Accumulated Costs	11,968,251	5	8,641		3,681,234	2,658	4
5	20	Dues, Fees, Suscriptions & Promo	Accumulated Costs	11,968,251	5	3,868		3,681,234	1,190	5
6	21	Clerical & General Office Exp.	Accumulated Costs	11,968,251	5	81,144	34,438	3,681,234	24,959	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs	11,968,251	5	49,230		3,681,234	15,142	7
8	24	Travel and Seminar	Accumulated Costs	11,968,251	5	23,590		3,681,234	7,256	8
9	25	Other Admin. Staff Transport	Accumulated Costs	11,968,251	5	19,444		3,681,234	5,981	9
10	26	Insurance - Prop., Liab., Malprac.	Accumulated Costs	11,968,251	5	16,713		3,681,234	5,141	10
11	30	Depreciation	Accumulated Costs	11,968,251	5	13,746		3,681,234	4,228	11
12	32	Interest	Accumulated Costs	11,968,251	5	202		3,681,234	62	12
13	33	Real Estate Taxes	Accumulated Costs	11,968,251	5	2,530		3,681,234	778	13
14	34	Rent - Facility & Grounds	Accumulated Costs	11,968,251	5	17,395		3,681,234	5,350	14
15	35	Rent - Equipment & Vehicles	Accumulated Costs	11,968,251	5	7,674		3,681,234	2,360	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 593,992	$ 378,383		$ 182,703	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Mortgage Loan	$26,697.36	4/17/00	$ 3,720,700	$ 3,639,933	5/1/2035	8.1000	$ 295,921	1
2	Chrysler Financial		X	Vehicle Loan	$658.80	9/30/00	23,391		9/30/03	0.9000	26	2
3												3
4									Loan Cost Amortization		5,177	4
5												5
	Working Capital											
6	First National Bank		X	Line of Credit	N/A	1/4/03	100,000	1	1/4/04	Prime+1	633	6
7									Home Office Allocation		62	7
8												8
9	TOTAL Facility Related				$27,356.16		$ 3,844,091	$ 3,639,934			$ 301,819	9
	B. Non-Facility Related*											
10									Interest Income		(6,737)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,737)	14
15	TOTALS (line 9+line14)						$ 3,844,091	$ 3,639,934			$ 295,082	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 18,266** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	41,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,692	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,692	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	44,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	23,681	8
	1999	23,468	9
	2000	23,113	10
	2001	27,516	11
	2002	42,692	12

Line 2: 2002 Taxes Paid

Line 4: Accrual is based on 2002 taxes paid.

Line 7: $44,692 + $778 (Home Office R.E. Tax Allocation) = $45,470 Total R.E. Taxes - Schedule V, Col. 8.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nursing and Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE 618-465-7717 FAX #: 618-465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-875-004-00	Outlots 59,62,63 & 64 S Pt Outlot 62	$ 39,608.86	$ 39,608.86
2.	04-208-017-00	S28 T8 R11 Unplatted Parcels	$ 3,082.64	$ 3,082.64
3.		S & W PT SE 1/4 NE 1/4 Less E PT	$	$
4.		Less .10 ACS for Hwy	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,691.50	$ 42,691.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,948 B. General Construction Type: Exterior Brick & Siding Frame Steel & Brick Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 1,180,668	$ 47,227	25	$ 47,227	$	$ 460,462	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			1994	26,304	2,469	5-10	2,469		25,108	9
10	Exterior Remodeling			1994	10,000	667	15	667		6,389	10
11	Flooring			1994	29,698	2,970	10	2,970		27,891	11
12	Electrical			1994	11,690	585	20	585		5,404	12
13	Air Conditioning			1994	25,830	2,583	10	2,583		24,108	13
14	Interior Remodeling			1994	40,265	1,359	5-20	1,359		32,254	14
15	Shed			1994	3,267	327	10	327		3,158	15
16	Nurses' Station			1994	6,055	303	20	303		2,901	16
17	Home Office Wallpapering/Flooring			1994	4,863		5			4,863	17
18	Painting			1995	7,392		5			7,392	18
19	Electrical			1995	3,382	338	10	338		2,987	19
20	Call Lights			1995	1,564	104	15	104		860	20
21	Storage Building			1996	3,500	350	10	350		2,450	21
22	2 Boilers			1996	7,400	370	20	370		2,929	22
23	Roof Repair & Drains Installed			1996	3,619	362	10	362		2,805	23
24	Ceiling Tile & End Caps			1996	3,506	292	12	292		2,094	24
25	Storage Building			1997	3,356	336	10	336		2,322	25
26	Alarm System			1997	1,750	175	10	175		1,210	26
27	Wallcovering			1997	6,355	318	5-10	318		5,295	27
28	Ceiling Tile			1997	1,485	124	12	124		804	28
29	3 Windows & Sills & 1 Door Replaced			1997	4,108	274	15	274		1,734	29
30	Baseboards Remodeled			1997	1,166	117	10	117		739	30
31	Air Conditioner Unit			1997	2,185	218	10	218		1,414	31
32	Concrete Pation & Sidewalk			1997	1,842	123	15	123		778	32
33	Rock			1997	502		5			502	33
34	Landscaping			1997	1,075	107	10	107		717	34
35	Roofing			1998	2,592	259	10	259		1,534	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower Room Remodeled	1998	$ 1,437	$ 144	10	$ 144	$	$ 850	37
38	Baseboard Remodeling	1998	1,919	192	10	192		1,079	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		7,019	39
40	Wallcoverings	1998	1,495	149	10	149		760	40
41	4 Air Conditioning Units	1999	2,840	284	10	284		1,254	41
42	Roofing	1999	35,386	3,539	10	3,539		16,808	42
43	Home Office Wallpapering	1999	818		5	163	163	791	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		724	44
45	Wallcoverings	2000	2,231	446	5	446		1,524	45
46	Chair Railings	2000	6,267	418	15	418		1,285	46
47	Cove Base	2000	1,797	180	10	180		539	47
48	Constr. Of 400 Wing - Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		6,772	48
49	Constr. Of 400 Wing - Contractor Costs	2001	943,708	37,748	25	37,748		94,371	49
50	Constr. Of 400 Wing - Drawings, Surety Bond & Misc.	2001	11,223	449	25	449		1,122	50
51	Constr. Of 400 Wing - Interest & Mortgage Ins. Premiums	2001	89,316	3,573	25	3,573		8,932	51
52	400 Wing Nurse Call System	2001	10,104	674	15	674		1,684	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		490	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		2,449	54
55	400 Wing Telecommunication System	2001	4,025	402	10	402		1,006	55
56	400 Wing Door Monitor System	2001	2,640	264	10	264		660	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		1,507	57
58	400 Wing Signage	2001	1,161	232	5	232		580	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	155	15	155		386	59
60	400 Wing Chair Rails, Wallpaper & Border	2001	4,208	842	5	842		2,104	60
61	400 Wing Door Guards	2001	607	121	5	121		303	61
62	400 Wing Cubicle Tracks & Curtains & Window Treatments	2001	15,188	1,962	5-20	1,962		4,906	62
63	Landscaping, Shrubs & Trees	2001	11,744	1,174	10	1,174		3,230	63
64	Fencing	2001	4,200	525	8	525		1,400	64
65	Wallpaper & Border-Existing Facility	2001	55,671	11,134	5	11,134		32,700	65
66	Storage Building	2001	3,268	327	10	327		926	66
67	Carpet-Administrative Offices	2001	2,687	537	5	537		1,523	67
68	Nurse Call System Services-Existing Facility	2001	3,700	247	15	247		637	68
69	Alarm System Services-Existing Facility	2001	3,903	260	15	260		781	69
70	TOTAL (lines 4 thru 69)		$ 2,725,230	$ 134,315		$ 134,478	$ 163	$ 832,206	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,725,230	$ 134,315		$ 134,478	$ 163	$ 832,206	1
2	Replacement Signage-Existing Facility	2001	3,656	731	5	731		2,072	2
3	Door Guards - Existing Facility	2001	1,979	396	5	396		1,022	3
4	Vinyl Flooring & Cove Base 400 Wing	2001	11,615	1,162	10	1,162		2,904	4
5	25 Overbed Lights	2001	1,625	162	10	162		393	5
6	Painting Door Frames	2001	8,932	1,786	5	1,786		4,913	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		115	7
8	Mini Blinds, Valances & Rods	2001	14,744	2,949	5	2,949		6,389	8
9	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		3,785	9
10	A/C Units	2001	3,424	342	10	342		872	10
11	Overbed Lights	2002	3,055	306	10	306		563	11
12	Cubicle Curtains	2002	6,155	1,231	5	1,231		2,171	12
13	2 A/C Units	2002	1,398	140	10	140		233	13
14	Security Camera System	2002	1,010	202	5	202		303	14
15	Fire Doors	2002	1,543	103	15	103		154	15
16	Roofing-North Entrance	2002	1,680	168	10	168		196	16
17	Wall Guard & End Caps	2002	1,497	100	15	100		116	17
18	Door Canopy	2003	3,800	253	15	253		253	18
19	Landscaping	2002	1,729	173	10	173		216	19
20	Home Office Light Fixtures	2002	296		10	30	30	57	20
21	Landscaping, Plants, Trees	2003	18,903	778	10	778		778	21
22	A/C Units	2003	5,551	296	10	296		296	22
23	Home Office Cabinets	2003	1,284		10	64	64	64	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,834,254	$ 147,060		$ 147,317	$ 257	$ 860,071	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 266,219	$ 24,586	$ 26,073	$ 1,487	5-20	$ 98,553	71
72	Current Year Purchases	11,831	638	752	114	5-12	752	72
73	Fully Depreciated Assets	280,686	1,476	2,015	539	5-7	280,686	73
74								74
75	TOTALS	$ 558,736	$ 26,700	$ 28,840	$ 2,140		$ 379,991	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2000 Dodge Grand Caravan	2000	$ 24,916	$ 6,229	$ 6,229	$	4	$ 20,244	76
77	Home Office Admin	2000 Taurus	2000	7,326		1,831	1,831	4	6,105	77
78										78
79										79
80	TOTALS			$ 32,242	$ 6,229	$ 8,060	$ 1,831		$ 26,349	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,496,896	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,217	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,228	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,266,411	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 7,712 Description: Copier $6,205; Postage Machine $605; Bi-pap Machine $902.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			165		165
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		1,998		1,998
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			400		400
9	TOTALS		$	$ 2,563	$	$ 2,563
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,563			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	5111 hrs	$ 133,552		$	$ 346	5,111	$ 133,898	1
2	Licensed Speech and Language Development Therapist	10a,8	1452 hrs	49,540				1,452	49,540	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	4711 hrs	125,115			121	4,711	125,236	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				172,639		172,639	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-Rays Other (specify): Lab Fees	39,3 39,3				3,361 13,945			3,361 13,945	13
14	TOTAL			$ 308,207		$ 17,306	$ 173,106	11,274	$ 498,619	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center **#** 0039339 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400,714	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,000)	746,207		3
4	Supply Inventory (priced at cost)	11,077		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,903		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	84,713		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,274,614	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	152,155		13
14	Buildings, at Historical Cost	2,746,502		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	563,101		16
17	Accumulated Depreciation (book methods)	(1,239,911)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	41,366		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	162,010		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,455,523	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,730,137	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,733	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	64,692		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,373		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Stockholder	85,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 663,799	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,398		39
40	Mortgage Payable	3,639,933		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,663,331	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,327,130	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (596,993)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,730,137	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (674,601)	1	
2	Restatements (describe):		2	
3	**Prior Year Expense Booked After C/R Filed**	(10,500)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (685,101)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	88,108	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 88,108	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (596,993)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,262,470	1
2	Discounts and Allowances for all Levels	(811,847)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,450,623	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	25,739	5
6	Therapy	648,642	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 674,381	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,449	13
14	Non-Patient Meals	669	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	161,613	19
20	Radiology and X-Ray	3,078	20
21	Other Medical Services	46,695	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 213,504	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,737	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,737	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	1,193	28
28a	Miscellaneous Income	7,677	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,870	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,354,115	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	754,300	31
32	Health Care	1,833,120	32
33	General Administration	872,463	33
	B. Capital Expense		
34	Ownership	560,882	34
	C. Ancillary Expense		
35	Special Cost Centers	189,945	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,266,007	40
41	**Income before Income Taxes (line 30 minus line 40)****	88,108	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 88,108	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,219	2,365	$ 51,045	$ 21.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,819	15,581	277,261	17.79	3
4	Licensed Practical Nurses	14,705	15,426	237,998	15.43	4
5	Nurse Aides & Orderlies	69,538	73,272	626,265	8.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,501	4,021	37,555	9.34	8
9	Activity Director					9
10	Activity Assistants	3,881	4,198	34,664	8.26	10
11	Social Service Workers	4,773	4,796	57,902	12.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,738	25,492	171,960	6.75	15
16	Dishwashers					16
17	Maintenance Workers	3,829	4,175	44,349	10.62	17
18	Housekeepers	12,753	13,271	87,299	6.58	18
19	Laundry	10,249	11,064	75,244	6.80	19
20	Administrator	2,162	2,239	72,986	32.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,894	4,204	49,074	11.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,781	2,088	21,924	10.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,842	182,192	$ 1,845,526 *	$ 10.13	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 3,728	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	24	1,116	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,500	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,318	11,3	44
45	Social Service Consultant	23	1,318	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	6,104	10,3	47
48					48
49	TOTAL (lines 35 - 48)	194	$ 24,684		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terrie Weible	Administrator	0.00	$ 72,986
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,986

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 156,274
Health Care financial, L.L.C. - Management Fees	60,773
TOTAL (agree to Schedule V, line 17, col. 3)	$ 217,047
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Fees	$ 44,959
Hughes & Associates	Audit Fees	5,391
Ted Frapolli	Legal Fees	1,960
McMahon, Berger, Hanna, et al	Legal Fees	742
Scott W. Schultz	Legal Fees	166
Montgomery Nursing & Rehab	Medicare Billing Consultant	1,150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 54,368

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,550
Unemployment Compensation Insurance	11,847
FICA Taxes	133,991
Employee Health Insurance	23,154
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Disability Insurance	532
Employee Dental Insurance	400
Staff Relations	5,743
Employee Physicals	176
Home Office Employee Benefits	15,142
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,535

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,575
Health Care Worker Background Check	
(Indicate # of checks performed 46)	552
Licenses & Fees	416
Dues & Subscriptions	5,923
Service Charge	898
IHCA Dues	
Home Office Dues & Subs	1,190
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,754

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,384
Seminar Expense	2,485
Home Office Travel & Seminar	7,256
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,125

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $3,326**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,117** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **669**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **12%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Husghes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2003

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(3,147)
BARBER & BEAUTY SHOPS	40	32
ACTIVITIES	11	780
NURSE AIDE TRAINING	13	165
NURSING & MEDICAL RECORDS	10	2,170
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	400
DUES, FEES SUBSCRIPTIONS & PROMOS	20	(400)
To reclass CNA test fees to proper lines		
DUES, FEES SUBSCRIPTIONS & PROMOS	20	136
TRAVEL & SEMINAR	24	(136)
To reclass dues to proper lines		
NURSE AIDE TRAINING	13	1,998
NURSING & MEDICAL RECORDS	10	(1,998)
To reclass CNA trainer wages		

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28a
12/31/2003

EMPLOYEE FLU SHOTS	105
PROMO ADS REIMBURSEMENTS	233
TELEPHONE EXPENSE REFUNDS	371
MEDICAL SUPPLIES REIMBURSEMENTS	847
DIETARY FOOD REIMBURSEMENTS	823
REVERSAL OF PRIOR YEAR ACCRUAL OF DISALLOWED INSURANCE DEDUCTIBLE	5,000
OTHER MISCELLANEOUS INCOME	298
	7,677

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2003

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/MEALS
Cindy Draper	ADON	10/23/2003	St. Louis, MO	Emergency Assessment & Preparation	PESI Healthcare	139	
Vicky Sauerwein	LPN	10/23/2003	St. Louis, MO	Emergency Assessment & Preparation	PESI Healthcare	139	
Ann Amos	VP Of Operations	5/22-5/23/03	Jefferson City, MO	The Procrastinators Seminar	Missouri Health Care Association	140	242
Terrie Weible	Administrator	5/22-5/23/03	Jefferson City, MO	The Procrastinators Seminar	Missouri Health Care Association	115	242
Renee Dille	COTA	2/27/2003	Jerseyville, IL	CPR Instructors Class	Jersey Community Hospital	90	
Jenny Stewart	Social Services	5/19/2003	Springfield, IL	Conference on Alzheimers Disease & Related Disorders	SIU School of Medicine	50	
Robin White	DON	7/16/2003	Springfield, IL	MDS Advanced Training	Illinois Health Care Association	90	
Carolyn Martin	MDS Coordinator	7/16/2003	Springfield, IL	MDS Advanced Training	Illinois Health Care Association	70	
Fannie Stewart	MDS Coordinator	7/16/2003	Springfield, IL	MDS Advanced Training	Illinois Health Care Association	70	
Robin White	DON	3/17/2003	Springfield, IL	IL New Medicaid Reimbursement System	Illinois Health Care Association	160	
Carolyn Martin	MDS Coordinator	3/12/2003	Springfield, IL	The MDS-What You Should Know	Illinois Health Care Association	90	
Terrie Weible	Administrator	4/1-4/2/03	Springfield, IL	INHAA Convention	Illinois Nursing Home Administrators Assoc.	105	258
Marcy Ballard	DON	11/12/2003	Springfield, IL	Restorative Nursing in Illinois	Illinois Health Care Association	90	
Fannie Stewart	MDS Coordinator	11/12/2003	Springfield, IL	Restorative Nursing in Illinois	Illinois Health Care Association	70	
Terrie Weible	Administrator	11/12-11/13/03	Peoria, IL	INHAA Convention	Illinois Nursing Home Administrators Assoc.	75	249
						1,493	992

Seminar Lodging/Meals	992
Home Office Travel & Seminar	7,256
Other Travel <$250 Each	1,384
Total Travel & Seminar, Line 24	11,125